

### **‘Driving to the edge of the cliff’: transgender mental health**

Three years ago a member of our family disclosed that they were transgender. The umbrella term transgender refers to ‘a significant minority of people whose gender expression or identity differs from societal expectations of their assigned sex at birth’ (Bailey et al. 2014). We had not faced anything like this before and we quickly learnt that transgender issues provoke strong opinions and emotions. For example, the angry reception Germaine Greer received at Cambridge University Union in 2015 following her well publicised views on transgender women (Huffington Post 2015). However, it seems clear from listening to transgender people that it is more difficult to live in the wrong biological body than it is to face the potential stigma, discrimination and distress from other people’s reactions and behaviour.

There is unsurprisingly a wide diversity in relation to transgender needs before, during and after transition. For example, the difference between the needs of young people and those of older people who ‘come out’ in later life. This latter group may have the added complexities of being married to an (at the time) opposite sex partner and with children. There are also differences in needs relating to transgender men and women. Transitioning from male to female may be more difficult because physical differences can prevent ‘passing’ as a woman in public. Furthermore, the needs of SOFFAs (significant others, family, friends and allies) are not well understood at all.

Most of the stories we hear in the media and literature are those of transgender people; the experiences of their families are often conspicuous by their absence. Although it is unclear why, given the mental distress experienced, transgender issues and those of SOFFAs have been overlooked in mental health nursing literature; Carol’s story in this edition of the journal offers insights into a wife’s experience (Watts et al. 2017). A common outcome of the mental distress experienced is attempted and completed suicide (Haas et al. 2014).

General Practitioners (primary care physicians) are likely to be the first point of contact but may refuse treatment or referral due to denial and negative attitudes (Bishop 2013). In desperation hormones might be bought off the internet without the necessary medical or emotional support or follow up (Department of Health 2008).

Where hormones are prescribed, there may be a lack of awareness of the need for monitoring.

Mental health services also have a clear role. However, negative experiences during encounters with staff have been enough to ensure that transgender people avoid them. Lack of trans-awareness and poor education on related topics have been reported (Bailey & McNeil 2013). Staff may not acknowledge transgender status, believing instead that gender dysphoria is a product of mental illness and if this is treated the feelings will go away. This is a problem, as it should not be assumed that the mental health needs of a transgender person relate to their gender identity. The location of 'gender dysphoria' in psychiatric diagnostic manuals serves to confuse the issues, where psychiatric diagnosis is sought as the only means of access to treatment and surgery for gender reassignment. As Bishop (2013) states:

'The current mental health support is inadequate and trans people are often caught in a Catch-22. If mental health issues are present, a patient may not be able to transition, which in itself can lead to deteriorating mental health. However, if they are considered completely mentally healthy, the perception is that they may not be able to demonstrate enough dysphoria to warrant a gender transition' (p. 30).

Therefore in conclusion, rather than driving transgender people to the edge of the cliff, as Pippa (the second author of the paper in this edition) puts it, the onus is on all of us to help people safely find 'the bridge' to the other side.

## References

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